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- ☐ Initial Application
- ☐ Change in Certification Type

        D          
(If an initial application leave blank, a number will be assigned)

Federal Tax Identification Number

Telephone No. (include area code) Fax No.(include area code)  
( ) ( )

**Mailing/Billing address** *(If different from street address, include attention line and/or Building, Floor, Suite)*

Number, Street

City                  State                  Zip Code

☐ Certificate of Waiver (*Complete Sections I - VI and VIII - X*)

☐ Certificate for Provider Performed Microscopy Procedures (PPMP) (*Complete Sections I - X*)

☐ Certificate of Compliance (*Complete Sections I- X*)

☐ Certificate of Accreditation (*Complete Sections I through X*) **and** indicate which of the following organization(s) your laboratory is accredited by for CLIA purposes, or for which you have applied for accreditation for CLIA purposes

☐ JCAHO    ☐ AOA    ☐ AABB

☐ CAP    ☐ COLA    ☐ ASHI

### III. TYPE OF LABORATORY (check the one most descriptive of facility type)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 01 Ambulatory Surgery Center  | <input type="checkbox"/> 09 Hospice                                      | <input type="checkbox"/> 17 School/Student Health Service                         |
| <input type="checkbox"/> 02 Community Clinic   | <input type="checkbox"/> 10 Hospital                                     | <input type="checkbox"/> 18 Skilled Nursing Facility/Nursing Facility             |
| <input type="checkbox"/> 03 Comp. Outpatient Rehab. Facility   | <input type="checkbox"/> 11 Independent                                  | <input type="checkbox"/> 19 Physician Office                                      |
| <input type="checkbox"/> 04 Ancillary Testing Site in Health Care Facility                               | <input type="checkbox"/> 12 Industrial                                   | <input type="checkbox"/> 20 Other Practitioner (specify) _____                    |
| <input type="checkbox"/> 05 End Stage Renal Disease Dialysis Facility                                    | <input type="checkbox"/> 13 Insurance                                    | <input type="checkbox"/> 21 Tissue Bank/Repositories                              |
| <input type="checkbox"/> 06 Health Fair  | <input type="checkbox"/> 14 Intermediate Care Fac. for Mentally Retarded | <input type="checkbox"/> 22 Blood Banks   |
| <input type="checkbox"/> 07 Health Main. Organization  | <input type="checkbox"/> 15 Mobile Laboratory                            | <input type="checkbox"/> 23 Rural Health Clinic/Federally Qualified Health Center |
| <input type="checkbox"/> 08 Home Health Agency   | <input type="checkbox"/> 16 Pharmacy                                     | <input type="checkbox"/> 24 Ambulance   |
| Is this a Medicare/Medicaid certified facility? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> 25 Other (specify) _____                                 |
| If yes, indicate Medicare provider number _____ Medicaid number _____                                    |  |   |

### IV. HOURS OF LABORATORY TESTING (list times during which laboratory testing is performed)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM: AM							
PM							
TO: AM							
PM							

(For multiple sites attach the additional information using the same format)

### V. MULTIPLE SITES (Must meet one of the regulatory exceptions to apply for this provision)

Are you applying for the multiple site exception?

- ☐ No **If no**, go to section VI. ☐ Yes **If yes**, provide total number of sites under this certificate \_\_\_\_\_ and complete remainder of this section .

**Indicate which of the following regulatory exceptions applies to your facility's operation.**

Is this a not-for-profit or Federal, State or local government laboratory engaged in limited (not more than a combination of 15 moderate complexity or waived tests per certificate) public health testing and filing for a single certificate for multiple sites? ☐ Yes ☐ No

If yes, list name, address and tests performed for each site below.

Is this a hospital with several laboratories located at contiguous buildings on the same campus within the same physical location or street address and under common direction that is filing for a single certificate for these locations? ☐ Yes ☐ No

If yes, list name or department, location within hospital and specialty/subspecialty areas performed at each site below.

**If additional space is needed, check here \_\_\_\_\_ and attach the additional information using the same format.**

NAME AND ADDRESS / LOCATION		TESTS PERFORMED / SPECIALTY / SUBSPECIALTY
Name of laboratory or hospital department		
Address/location (number, street, location if applicable)		
City, State, ZIP	Telephone No. ( )	
Name of laboratory or hospital department		
Address/location (number, street, location if applicable)		
City, State, ZIP	Telephone No. ( )	
Name of laboratory or hospital department		
Address/location (number, street, location if applicable)		
City, State, ZIP	Telephone No. ( )	

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**VI. WAIVED TESTING**

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Indicate the **estimated TOTAL ANNUAL TEST** volume for **all waived tests** performed. \_\_\_\_\_

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**VII. NONWAIVED TESTING (Including PPMP testing)**

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**If you perform testing other than or in addition to waived tests, complete the information below. If applying for one certificate for multiple sites, the total volume should include testing for ALL sites.**

**Place a check (✓) in the box preceding each specialty/subspecialty in which the laboratory performs testing.** Enter the estimated annual test volume for each specialty. **Do not include testing not subject to CLIA, waived tests, or tests run for quality control, calculations, quality assurance or proficiency testing when calculating test volume.** (For additional guidance on counting test volume, see the information included with the application package.)

**If applying for certificate of accreditation, indicate the name of the accreditation organization beside the applicable specialty/subspecialty for which you are accredited for CLIA compliance. (JCAHO, AOA, AABB, CAP, COLA or ASHI)**

SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME	SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME
<b>Histocompatibility</b>		_____	<input type="checkbox"/> <b>Hematology</b>		_____
<input type="checkbox"/> Transplant	_____		<b>Immunohematology</b>		_____
<input type="checkbox"/> Nontransplant	_____		<input type="checkbox"/> ABO Group & Rh Group	_____	
<b>Microbiology</b>		_____	<input type="checkbox"/> Antibody Detection (transfusion)	_____	
<input type="checkbox"/> Bacteriology	_____		<input type="checkbox"/> Antibody Detection (nontransfusion)	_____	
<input type="checkbox"/> Mycobacteriology	_____		<input type="checkbox"/> Antibody Identification	_____	
<input type="checkbox"/> Mycology	_____		<input type="checkbox"/> Compatibility Testing	_____	
<input type="checkbox"/> Parasitology	_____		<b>Pathology</b>		_____
<input type="checkbox"/> Virology	_____		<input type="checkbox"/> Histopathology	_____	
<b>Diagnostic Immunology</b>		_____	<input type="checkbox"/> Oral Pathology	_____	
<input type="checkbox"/> Syphilis Serology	_____		<input type="checkbox"/> Cytology	_____	
<input type="checkbox"/> General Immunology	_____		<input type="checkbox"/> <b>Radiobioassay</b>	_____	_____
<b>Chemistry</b>		_____	<input type="checkbox"/> <b>Clinical Cytogenetics</b>	_____	_____
<input type="checkbox"/> Routine	_____				
<input type="checkbox"/> Urinalysis	_____				
<input type="checkbox"/> Endocrinology	_____				
<input type="checkbox"/> Toxicology	_____				

**TOTAL ESTIMATED ANNUAL TEST VOLUME**\_\_\_\_\_

### VIII. TYPE OF CONTROL

Enter the appropriate two digit code from the list below \_\_\_\_ (enter only one code)

**Voluntary Nonprofit**

01 Religious Affiliation  
02 Private  
03 Other \_\_\_\_\_  
(Specify)

**For Profit**

04 Proprietary

**Government**

05 City  
06 County  
07 State  
08 Federal  
09 Other Government \_\_\_\_\_  
(Specify)

### IX. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

If the director of this laboratory serves as director for additional laboratories that are separately certified, please complete the following:

NAME OF LABORATORY	ADDRESS	CLIA IDENTIFICATION NUMBER

### X. INDIVIDUALS INVOLVED IN LABORATORY TESTING

Indicate the total number of individuals involved in laboratory testing (directing, supervising, consulting or testing). Do not include individuals who only collect specimens or perform clerical duties. For nonwaived testing, only count an individual one time, at the **highest** laboratory position in which they function. (Example Pathologist serves as director, technical supervisor and general supervisor. This individual would only be counted once (under director)).

**A. WAIVED TESTING**

Total No. of Individuals \_\_\_\_\_

**B. NONWAIVED TESTING(INCLUDING PPMP)**

Total No. of Individuals \_\_\_\_\_

Director \_\_\_\_\_ Technical supervisor \_\_\_\_\_  
Clinical consultant \_\_\_\_\_ General supervisor \_\_\_\_\_  
Technical consultant \_\_\_\_\_ Testing personnel \_\_\_\_\_  
Cytotechnologist \_\_\_\_\_

### ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION

ANY PERSON WHO INTENTIONALLY VIOLATES ANY REQUIREMENT OF SECTION 353 OF THE PUBLIC HEALTH SERVICE ACT AS AMENDED OR ANY REGULATION PROMULGATED THEREUNDER SHALL BE IMPRISONED FOR NOT MORE THAN ONE YEAR OR FINED UNDER TITLE 18, UNITED STATES CODE OR BOTH, EXCEPT THAT IF THE CONVICTION IS FOR A SECOND OR SUBSEQUENT VIOLATION OF SUCH A REQUIREMENT SUCH PERSON SHALL BE IMPRISONED FOR NOT MORE THAN 3 YEARS OR FINED IN ACCORDANCE WITH TITLE 18, UNITED STATES CODE OR BOTH.

CONSENT: THE APPLICANT HEREBY AGREES THAT SUCH LABORATORY IDENTIFIED HEREIN WILL BE OPERATED IN ACCORDANCE WITH APPLICABLE STANDARDS FOUND NECESSARY BY THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CARRY OUT THE PURPOSES OF SECTION 353 OF THE PUBLIC HEALTH SERVICE ACT AS AMENDED. THE APPLICANT FURTHER AGREES TO PERMIT THE SECRETARY, OR ANY FEDERAL OFFICER OR EMPLOYEE DULY DESIGNATED BY THE SECRETARY, TO INSPECT THE LABORATORY AND ITS OPERATIONS AND ITS PERTINENT RECORDS AT ANY REASONABLE TIME AND TO FURNISH ANY REQUESTED INFORMATION OR MATERIALS NECESSARY TO DETERMINE THE LABORATORY'S ELIGIBILITY OR CONTINUED ELIGIBILITY FOR ITS CERTIFICATE OR CONTINUED COMPLIANCE WITH CLIA REQUIREMENTS.

SIGNATURE OF OWNER/DIRECTOR OF LABORATORY (sign in ink)

DATE

# THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION (FORM HCFA-116)

## INSTRUCTIONS FOR COMPLETION

CLIA requires every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being to meet certain Federal requirements. If your facility performs tests for these purposes, it is considered, under the law, to be a laboratory. CLIA applies even if only one or a few basic tests are performed, and even if you are not charging for testing. In addition, the CLIA legislation requires financing of all regulatory costs through fees assessed to affected facilities.

The CLIA application (Form HCFA-116) collects information about your laboratory's operation which is necessary to determine the fees to be assessed, to establish baseline data and to fulfill the statutory requirements for CLIA. This information will also provide an overview of your facility's laboratory operation. All information submitted should be based on your facility's laboratory operation as of the date of form completion. **NOTE: WAIVED TESTS ARE NOT EXEMPT FROM CLIA. FACILITIES PERFORMING ONLY THOSE TESTS CATEGORIZED AS WAIVED MUST APPLY FOR A CLIA CERTIFICATE OF WAIVER.**

**THE GENERAL INFORMATION SECTION AND ALL APPLICABLE SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED TO THE FACILITY. PRINT LEGIBLY OR TYPE INFORMATION**

### I. GENERAL INFORMATION

**For an initial applicant, the CLIA identification number should be left blank. The number will be assigned when the application is processed.**

Be specific when indicating the name of your facility, particularly when it is a component of a larger entity e.g., respiratory therapy department in XYZ Hospital. For a physician's office, this may be the name of the physician. NOTE: The information provided is what will appear on your certificate.

Facility street address must be the actual physical location where testing is performed, including floor, suite and/or room, if applicable. **DO NOT USE A POST OFFICE BOX NUMBER OR A MAIL DROP ADDRESS FOR THE NUMBER AND STREET OF THE ADDRESS.** If the laboratory has a separate mailing or billing address, please complete that section of the application.

### II. TYPE OF CERTIFICATE REQUESTED

When completing this section, please remember that a facility holding a—

- **Certificate of Waiver** can only perform tests categorized as waived ;\*
- **Certificate for Provider Performed Microscopy Procedures (PPMP)** can only perform tests categorized as PPMP, or tests categorized as PPMP and waived tests;\*
- **Certificate of Compliance** can perform tests categorized as waived, PPMP and moderate and/or high complexity tests provided the applicable CLIA quality standards are met; and
- **Certificate of Accreditation** can perform tests categorized as waived, PPMP and moderate and/or high complexity tests provided the laboratory is currently accredited by an approved accreditation organization.\*\*

\*A current list of waived and PPMP tests may be obtained from your State agency. Specific test system categorizations can also be reviewed via the Internet on [www.cdc.gov/phppo/dls/](http://www.cdc.gov/phppo/dls/).

**\*\*If you are applying for a Certificate of Accreditation, you must include evidence of accreditation for your laboratory by an approved accreditation organization for CLIA purposes or evidence of application for such accreditation with the completed HCFA FORM-116.**

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### III. TYPE OF LABORATORY

Select the type of laboratory designation that is most appropriate for your facility from the list provided. If you cannot find your designation within the list, contact your State agency for assistance.

### IV. HOURS OF ROUTINE OPERATION

Provide only the times when actual laboratory testing is performed in your facility.

### V. MULTIPLE SITES

You can only qualify for the multiple site provision (more than one site under one certificate) if you meet one of the CLIA regulatory exceptions outlined on the form.

### VI. WAIVED TESTING

Include only the estimated annual volume for those tests that are waived.

### VII. NON-WAIVED TESTING (Including PPMP)

Follow the specific instructions on page 3 of the FORM HCFA-116 when completing this section. (Note: The Accrediting Organization column should reflect accreditation information for CLIA purposes only, e.g., JCAHO, etc.).

### VIII. TYPE OF CONTROL

Select the code which most appropriately describes your facility. Proprietary/for profit entities must choose "04".

### IX. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

List all other facilities for which the director is responsible. Note that for a Certificate of PPMP, Certificate of Compliance or Certificate of Accreditation, an individual can only serve as the director for no more than five certificates.

### X. INDIVIDUALS INVOLVED IN LABORATORY TESTING

Self explanatory

\*\*\*\*\*

Once the completed FORM HCFA-116 has been returned to the applicable State agency and it is processed, a fee remittance coupon will be issued. The fee remittance coupon will indicate your CLIA identification number and the amount due for the certificate, and if applicable the compliance (survey) or validation fee. If you are applying for a Certificate of Compliance or Certificate of Accreditation, you will initially pay for and receive a Registration Certificate. A Registration Certificate permits a facility requesting a Certificate of Compliance to perform testing until an onsite inspection is conducted to determine program compliance; or for a facility applying for a Certificate of Accreditation, until verification of accreditation by an approved accreditation organization is received by HCFA.

If you need additional information concerning CLIA, or if you have questions about completion of this form, please contact your State agency.

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# TESTS COMMONLY PERFORMED AND THEIR CORRESPONDING LABORATORY SPECIALTIES/SUBSPECIALTIES

## HISTOCOMPATIBILITY

HLA Typing (disease associated antigens)

## SYPHILIS SEROLOGY

RPR

FTA, MHA-TP

## GENERAL IMMUNOLOGY

Mononucleosis Assays

Rheumatoid Arthritis

Febrile Agglutinins

Cold Agglutinins

HIV

Antibody Assays (hepatitis, herpes, etc.)

ANA Assays

Mycoplasma pneumoniae Assays

## PARASITOLOGY

Direct Preps

Ova and Parasite Preps

Wet Preps

## BACTERIOLOGY

Gram Stains

Cultures

Sensitivities

Strep Screens

Antigen assays (chlamydia, etc.)

H. pylori

## MYCOBACTERIOLOGY

Acid Fast Smears

Mycobacterial Cultures

Sensitivities

## MYCOLOGY

Fungal Cultures

DTM

KOH Preps

## VIROLOGY

RSV

HPV assays

Cell cultures

## CHEMISTRY

### **Routine Chemistry**

Albumin

BUN

Ammonia

Uric acid

Bilirubin, Total

ALT/SGPT

Bilirubin, direct

AST/SGOT

Calcium

SGGT

Chloride

Alk Phos

Cholesterol, total

Amylase

CO<sub>2</sub>, total

CPK/CPK isoenzymes

Creatinine

CKMB

Glucose

HDL Cholesterol

pH

Iron

pO<sub>2</sub>

LDH

pCO<sub>2</sub>

LDH isoenzymes

Phosphorous

Magnesium

Potassium

Ferritin

Protein, total

Folic Acid

Sodium

Vitamin B12

Triglycerides

PSA

Folate

### **Urinalysis**

Automated urinalysis

Urinalysis with microscopic analysis

Urine specific gravity by refractometer

Urine specific gravity by urinometer

Urine protein by sulfasalicylic acid

### **Endocrinology**

TSH

Free T4

Total T4

Triiodothyronine (T3)

T3 Uptake

Serum-beta-HCG

### **Toxicology**

Acetaminophen

Blood alcohol

Carbamazepine

Digoxin

Ethosuximide

Gentamycin

Lithium

Phenytoin

Primidone

Procainamide

NAPA

Quinidine

Salicylates

Theophylline

Tobramycin

Valproic acid

**HEMATOLOGY**

WBC count  
RBC count  
Hemoglobin  
Hematocrit (Other than spun micro)  
Platelet  
Differential  
MCV  
Activated Clotting Time  
Prothrombin time  
Partial thromboplastin time  
Fibrinogen  
Reticulocyte count  
Manual WBC by hemocytometer  
Manual platelet by hemocytometer  
Manual RBC by hemocytometer  
Sperm count

**RADIOBIOASSAY**

Red cell volume  
Schilling's test

**IMMUNOHEMATOLOGY**

ABO group  
Rh(D) type  
Antibody Screening  
Antibody Identification  
Compatibility testing

**PATHOLOGY**

Dermatopathology  
Oral pathology  
PAP smear interpretations  
Other cytology tests  
Histopathology

**CYTOGENETICS**

Fragile X  
Buccal smear

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## GUIDELINES FOR COUNTING TESTS FOR CLIA

- o For **histocompatibility**, each HLA typing (including disease associated antigens), HLA antibody screen, or HLA crossmatch is counted as one test.
  - o For **microbiology**, susceptibility testing is counted as one test per group of antibiotics used to determine sensitivity for one organism. Cultures are counted as one per specimen regardless of the extent of identification, number of organisms isolated and number of tests/procedures required for identification.
  - o Testing for allergens should be counted as one test per individual allergen.
  - o For **chemistry** profiles, each individual analyte is counted separately.
  - o For **urinalysis**, microscopic and macroscopic examinations, each count as one test. Macroscopics (dipsticks) are counted as one test regardless of the number of reagent pads on the strip.
  - o For **complete blood counts**, each measured individual analyte that is ordered and reported is counted separately. Differentials are counted as one test.
  - o Do not count calculations (e. g., A/G ratio, MCH, and T7), quality control, quality assurance and proficiency testing assays).
  - o For **immunohematology**, each ABO, Rh, antibody screen, crossmatch or antibody identification is counted as one test.
  - o For **histopathology**, each block (not slide) is counted as one test. Autopsy services are not included. For those laboratories that perform special stains on histology slides, the test volume is determined by adding the number of special stains performed on slides to the total number of specimen blocks prepared by the laboratory.
  - o For **cytology**, each slide (not case) is counted as one test for both Pap smears and nongynecologic cytology.
  - o For **cytogenetics**, the number of tests is determined by the number of specimen types processed on each patient, e.g., a bone marrow and a venous blood specimen received on one patient is counted as two tests.
-